Alaska Rural Primary Care Facility Needs Assessment

Denali Commission

Dated Material – Please Read Immediately

ALASKA RURAL PRIMARY CARE FACILITY NEEDS ASSESSMENT

March 22, 2000

Dear Community Leader:

The Denali Commission is undertaking a process to determine the status of rural primary care facility infrastructure and health care delivery systems throughout Alaska. This work is being accomplished in partnership with the Alaska Native Tribal Health Consortium (ANTHC), Indian Health Service (IHS), and the Alaska Department of Health and Social Services (DHHS).

The "Alaska Rural Primary Care Facility Needs Assessment Questionnaire" was developed to determine the unmet primary care facility needs in your community. You were identified as a contact person for your community. We anticipate that you will talk with the other people in your community who can best assist you with the technical parts of this questionnaire. You may need to talk with several people with health care and facilities expertise to provide the most accurate responses. A project overview and detailed instructions are included with the attached questionnaire. **The questionnaire must be completed and returned by April 25, 2000.**

Your participation in this project is entirely voluntary but very important. If information is not received from your community, it may affect the ability of the Denali Commission to address any primary health care facilities needs in your community.

Many of you responded to our earlier request (January 2000) for input on criteria to be used to determine a prioritization methodology for allocation of funding. You will have additional opportunities to contribute to that process. There will be a teleconference at the twenty-two Legislative Information Office sites throughout Alaska on July 11, 2000 from 9:00-11:00 AM. On the same date, July 11, there will also be a Denali Commission Public Hearing in Anchorage at the Assembly Chambers in the Loussac Library. A presentation is scheduled for 12:30 – 1:00 PM followed by public testimony from 1:00 – 4:00PM.

If you have any questions after reviewing the materials, please do not hesitate to contact the Project Manager, Gary Kuhn, P.E., either on the web site or by calling him in Anchorage at 1-800-560-8637 ext. 3604.

Sincerely,

Paul Sherry
President, CEO
Alaska Native Tribal Health Consortium

Karen Perdue
Commissioner
Department of Health and Social Services

3925 Tudor Centre Drive, Anchorage, Alaska 99508
Phone: (907) 729-3606 Facsimile: (907) 271-4735
Web: http://ruralhealthcare.geonorth.com

PROJECT OVERVIEW

Denali Commission and Health Care Facilities

The Denali Commission Act of 1998 (see *www.denali.gov*) created the Denali Commission (Commission). Three general areas of focus were identified for the Commission including job training, economic development and rural infrastructure development. The Commission is based upon a format similar to the Appalachian Regional Commission (ARC), which was created in 1965. Of interest to the Denali Commission and Alaskans is that the ARC (in partnership with the 13 eastern-seaboard states it serves) arrived at five broad goals including: "Appalachian residents will have access to affordable, quality health care." Correspondingly, the seven Denali Commissioners recently identified rural health care facilities and services as the second area of focus or theme for infrastructure related projects funded and supported by the Commission. The first infrastructure focus for the Commission was rural energy projects.

Agreement for the Needs Assessment

In October 1999, the Commissioners approved funding for a project with the Alaska Native Tribal Health Consortium (ANTHC) for a needs assessment of rural primary care facilities. ANTHC offered to provide project management and a portion of their own funds for a needs assessment project. In light of the mission to provide federal services for all of Alaska, the Commission and ANTHC sought the participation of the Alaska Department of Health and Social Services (DHSS) to obtain representation for all rural communities. After DHSS agreed to participate in the needs assessment project, the three parties then sought the participation of the Indian Health Service (IHS), based upon their long history and in-depth knowledge of rural primary care programs and facilities. On February 24, 2000, the four partners entered into an agreement for carrying out the Alaska Rural Primary Care Facility Needs Assessment project. The project will address needs in all Native and non-Native communities in the state that meet the following basic criteria:

- Year-round community population of at least 20 individuals
- No direct access to an in-patient health care facility

Goals of the Needs Assessment Project

The needs assessment project will accomplish three main tasks. First, a database will be created that provides detailed information on health care facilities and program services. Data will be obtained via a statewide questionnaire. Additional information from existing databases maintained by other agencies will also be gathered to complement information obtained from the questionnaire. Second, a report with a statewide cost estimate will be generated that summarizes the magnitude of primary care facility needs in Alaska. The goal is to provide this report to the Alaska Congressional delegation by July 1, 2000. Third, the needs assessment project will develop a resource distribution methodology for rural primary care facilities by October 1, 2000. The partners will strive to obtain maximum public participation in developing this methodology. The outcome of this effort is intended to be an equitable system for distribution of federal funding to those communities with the greatest need, recognizing that cost effective delivery of service includes the ability of a community to operate and maintain the facility over the long-term.

Information from the needs assessment project will be used by the partners to seek funding for both facilities and primary care services. In the event Congress looks favorably on the July 2000 report, the methodology should guide Federal, State and Tribal managers on which projects should be funded.

Project Team

A project Steering Committee has been formed that includes representatives from the Denali Commission, ANTHC, IHS and DHSS. The committee and all four parent organizations will be collaborating with stakeholders throughout the project.

ANTHC has been tasked with the overall responsibility for developing a work plan and schedule to meet project goals. ANTHC and the Steering Committee will receive assistance from two primary consultants during the project; NANA/DOWL JV (health facility expertise) and GEONORTH, Inc. (computer expertise). These services were obtained through an existing indefinite delivery contract between ANTHC and NANA/DOWL. The Commission and ANTHC agreed to use this contract in order to expedite the project and meet the July 1 report milestone.

Future Efforts

The four partners have accepted that this needs assessment project is only the beginning. They are in the process of developing a follow on scope of work to address more specific program needs and "deep look" surveys (to document code and other deficiencies at existing facilities).

At the close of last year's Congressional calendar, legislation was passed that authorized demonstration health projects between the Commission and U.S. Department of Health and Human Services. Demonstration projects can extend beyond primary care facilities, for example, into hospitals, mental health facilities and child care facilities. Although no funding was appropriated, one avenue is now in place for future federal support. Hopefully, the efforts of the Alaska Rural Primary Care Facility Needs Assessment project will help convince Congress to address unmet primary care needs in rural Alaska.

Communications

A web site has been established to facilitate communications during the project. Please refer to *http://ruralhealthcare.geonorth.com* for additional information on this initiative and e-mail links to the ANTHC project office. You can also contact the project office toll free by calling 800-560-8637 ext. 3606.

QUESTIONNAIRE

Alaska Rural Primary Care Facility Needs Assessment

Developed by:

Alaska Native Tribal Health Consortium
Indian Health Service
State of Alaska, Department of Health and Social Services

Prepared for:

Denali Commission

Return by April 25, 2000

to

Alaska Native Tribal Health Consortium
3925 Tudor Centre Drive
Anchorage, Alaska 99508

Phone: (800) 560-8637 ext. 3606 • Fax: (907) 271-4735
Website: http://ruralhealthcare.geonorth.com

INSTRUCTIONS

Questionnaire Design

The questionnaire is divided into two main sections that address the status and additional needs with respect to primary health care facilities and services/programs. All subsections and questions in the main questionnaire are identified with either an **F** (facilities) or **P** (program) prefix. The partners in the project have agreed that an assessment of program needs is essential and must be included in any evaluation of facility condition and/or additional space needs. Please be aware that the data you submit now may be enhanced in subsequent phases of the project.

Getting Started

1. Locate your 3-digit unique identifying number on the mailing label on the back of this packet.
2. Determine how many "**Facilities**" and "**Program**" sections of the questionnaire should be completed for your community. You will be able to make this determination after completing the "**General**" section of the questionnaire. Make the appropriate number of copies of the Facilities section and the Program section.
3. Review the major headings in each section of the questionnaire and then identify the appropriate people to assist with data collection for your community. You may need to talk with several people with facilities and health care expertise to provide the most accurate responses.
4. Determine if your site will submit data electronically (via the Internet), by mail or by fax. If you are submitting by mail or fax, please remember to fill in all the identifying information (Organization, Facility Name and Unique Identifying Number) at the top of each section that will be submitted.
5. Complete the questionnaire. *Note: even if you intend to submit the final data via the Internet, it is recommended that you first complete a "working paper copy" of the questionnaire.*
6. Submit your data.

Complete Questionnaires and Submit Data by April 25, 2000

THREE WAYS TO SUBMIT YOUR DATA

❶

INTERNET

Access the project web site:
http://ruralhealthcare.geonorth.com

Then click on the questionnaire icon and follow the on-line instructions

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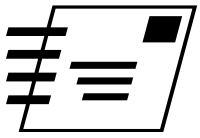
❷

Mail completed questionnaire to:

Alaska Native Tribal Health Consortium
Alaska Rural Primary Care Facility Needs Assessment
Project Office
3925 Tudor Centre Drive
Anchorage, Alaska 99508



MAIL

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❸

FAX

You may also submit your data by faxing a completed questionnaire to:

(907) 271-4735

Have a question? See the Help Desk on the project web site:

(http://ruralhealthcare.geonorth.com)

or call…

General & Facility Related Questions

Alaska Rural Primary Care Facility Needs Assessment Project Office
Alaska Native Tribal Health Consortium
800-560-8637 extension 3606

Gary Kuhn, P.E., Project Manager
e-mail: *gkdenali@anthc.org*

Rebecca Woodall, Project Assistant
e-mail: *rwdenali@anthc.org*

Program Related Questions

Patricia Carr, MPH, Program Manager
Primary Care & Health Promotion Unit
Alaska Department of Health and Social Services
907-465-8618
e-mail: *pat_carr@health.state.ak.us*

Torie Heart, MS, RN, Director
Community Health Aide Program
Alaska Area Native Health Service
907-729-3642
e-mail: *vheart@anmc.org*

Other Information

Other existing data sources will be used to enhance the information that each community is able to provide via this questionnaire. At this time, the project team envisions using the following existing data sources to round out the database:

- State of Alaska, Department of Community and Economic Development, community profile database Web site: *http://www.dced.state.ak.us/mra/CF_COMDB.htm*
- Alaska EMS Goals, (Fourth Edition)
- Indian Health Service Data System, (Health System Workload Data)
- Indian Health Service Facilities Database
- State Public Health Nursing Database
- ADOT&PF Airport Runway Inventory

Estimated Time to Complete

It is anticipated that if support people and data are readily available, the questionnaire will take at least 90 minutes to complete. If there are multiple facilities and/or primary care organizations in your community, it may take longer.

Confidentiality

Although the general public can access the project web site, all electronic responses are confidential. All responses received by mail and fax are also confidential.

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GENERAL

Community_____Unique ID #_____

G1.1 Is there an existing primary care facility (or facilities) in your community? Check the box that best describes the situation in your community (see subsection P1 in the Program section of the Questionnaire for more detail on the categories of primary care services being used in this survey)**.**

☐ (a) NO – but there is a facility in an adjacent community that provides primary care services for us; we do not need a stand-alone facility of our own.

If you answered NO to (a), enter the name of the adjacent community below, sign the certification on page 2 and then stop. You do not need to complete any other sections of this questionnaire.

Adjacent Community: _____

☐ (b) NO – and our community needs one.

If you answered NO to (b), complete the entire Program section and subsection F4.0 of the Questionnaire.

☐ (c) YES – one central facility that houses all health related services is currently available.

If you answered YES to (c), complete one Facilities and one Program section of the Questionnaire.

☐ (d) YES – one organization / program, but somewhat decentralized. One or more primary care services are housed in stand-alone building(s) remote from the main facility.

If you answered YES to (d), list all the different facilities (major stand-alone buildings, separate leased space in larger buildings and/or donated space) that are used to deliver primary care services in the community, then complete a Facilities section of the Questionnaire for each major facility. Please also complete the Program section. For example, if the organization / program providing services utilizes two different major buildings, you would complete one Program section and two Facilities sections of the Questionnaire.

	Facility Name	***Services Provided***
1.	_____	_____
2.	_____	_____
3.	_____	_____

☐ (e) YES - and there are two or more different organizations that provide primary care services in the community.

If you answered YES to (e), list all the different organizations and facilities (major stand-alone buildings, separate leased space in larger buildings and/or donated space) that are used to deliver primary care services in the community, then complete one or more Program sections of the Questionnaire. Complete an entire Program section for each separate organization that provides primary care. The total number of Program sections to be submitted will depend on your assessment of how many it takes to adequately paint a complete primary care picture for the community. You should also complete a Facilities section for each major facility used to deliver services, regardless of the organization that delivers the service. For example, if there are two organizations in the community that provide various primary care services, one utilizing three different major buildings and one that only operates out of one building, you would complete two Program sections and four Facilities sections of the Questionnaire.

	Organization	***Facility Name***	***Services Provided***
A.	_____	_____	_____
			_____
		_____	_____
			_____
B.	_____	_____	_____
			_____
		_____	_____
			_____
C.	_____	_____	_____
			_____
		_____	_____
			_____

Note: *If you answered YES to either (d) or (e) please do not fill out a separate Facilities section for small ancillary structures (i.e., unheated storage buildings, etc.). Instead, associate them with an appropriate major building and then provide an overall response to the questions for that "facility". If you are not sure how many sections of the questionnaire to complete, due to a unique multiple building, program and/or mixed use situation, please call the HELP DESK for guidance (800-560-8637 extension 3606).*

This section of the Questionnaire was completed by:

_____ _____

Signature *Date*

_____ _____

Printed Name *Position*

FACILITIES

Community_____ **Unique ID #**_____

Organization_____

Name of Facility_____

F1.0 Basic Data

F1.1 Is this facility included in a written facilities master plan for the organization / program?

- ☐ NO
- ☐ YES
- ☐ Master plan is under development

If yes, has the plan been coordinated with any of the following? Check all that apply.

- ☐ Main referral facility (next level of care)
- ☐ Regional Native Health Corporation
- ☐ Parent Organization
- ☐ Other *(list)* _____

F1.2 Is the facility included in the Indian Health Service (IHS) Facilities Database?

- ☐ NO
- ☐ YES

If yes, please provide the unique identifying number(s) from the IHS database so we can match the data provided in this questionnaire with the correct building in their database.

Facility No. _____

Building No. _____

F1.3 Does the health program share the facility with other non-medical tenants?

- ☐ NO
- ☐ YES

If yes, total non-medical space in the building = _____ *Gross Square Feet (GSF)*

- ☐ Don't Know

F1.4 Is a detailed floor plan available for the space occupied by the health program?

- ☐ NO
- ☐ YES

F1.5 How much space does your health program use in the facility?

Direct services & support: _____ *GSF*

Staff quarters: _____ *GSF*

Other (list) _____*:* _____ *GSF*

☐ Don't Know

☐ Use values in IHS Facilities Database

☐ Use value in 1994 State DHSS Village Clinic Survey

F1.6 Check the box below that most closely describes the construction of the facility.

☐ Wood Frame – single story

☐ Wood Frame – multi-story

☐ Steel Frame (commercial type building) – single story

☐ Steel Frame (commercial type building) – multi story

☐ Other

F1.7 Is the facility protected with an automatic sprinkler system?

☐ NO

☐ YES

F1.8 Does the facility have a central fire alarm system?

☐ NO

☐ YES

F1.9 Does the facility have a standby generator?

☐ NO

☐ YES

F1.10 Is the facility insured against loss by fire and other perils through a commercial premium-based policy?

☐ NO

☐ YES

Comments:

F2.0 Ownership / Lease Data

F2.1 Who owns the facility?

- ☐ City
- ☐ State
- ☐ U.S. Public Health Service
- ☐ IRA
- ☐ Regional Native Health Corporation
- ☐ Village Corporation
- ☐ Private Individual
- ☐ Other *(list)* _____

F2.2 Is the facility leased from another party?

- ☐ (a) NO *If no, go to question F2.3.*
- ☐ (b) YES

If yes, check the box that best describes the type of lease.

- ☐ Full service (owner provides all repairs, utilities and maintenance)
- ☐ Triple Net (tenant provides all repairs, utilities and maintenance)
- ☐ Other *(list)* _____

Are there adequate funds to cover the entire lease and/or your share of the ownership, repair, utility and maintenance costs?

- ☐ (c) NO
- ☐ (d) YES

F2.3 If the facility is owned by a local or regional organization, and another entity pays lease money to operate the clinic, are the funds adequate to cover the cost of ownership, repairs, utilities and maintenance?

- ☐ NO
- ☐ YES
- ☐ N/A

F2.4 If your organization owns the facility and is self supporting, are there adequate funds to cover the cost of ownership, repairs, utilities and maintenance?

- ☐ NO
- ☐ YES
- ☐ N/A

F2.5 If you answered "NO" to F2.2(c), F2.3 or F2.4, check the box that most accurately describes the annual funding shortfall at the facility with respect to ownership, repair, utility and maintenance costs.

- ☐ $1 - $10,000
- ☐ $10,001 - $25,000
- ☐ $25,001 - $50,000
- ☐ Greater than $50,000

Comments:

F3.0 Physical Deficiencies

Rate the condition of the facility with respect to the following categories. Use the good, fair, and poor guidelines summarized below.

Structural: *Related to structure or fabric of the building, including foundation, roof, framing, windows and interior finishes*

Mechanical: *Plumbing, heating, ventilation and other special systems (e.g., medical gas)*

Electrical: *Electrical distribution and emergency/standby power systems. Also includes low voltage wiring and control systems for telephone, paging, alarm systems, etc.*

Energy Management: *Energy efficiency of building envelope and mechanical and electrical systems*

Handicap Access: *Compliance with the Americans with Disabilities Act (ADA)*

Site / Environmental*:* *Flood hazard, inadequate water and sewer connections, setback problems and known spills of hazardous materials on the immediate property, etc.*

Fire / Life Safety*:* *Construction requirements related to fire protection contained in the Uniform Fire Code (UFC), Uniform Building Code (UBC) and the National Fire Protection Association Life Safety Code (NFPA 101)*

Floor Plan: *Overall workflow issues related to staff and patient circulation patterns, room proximities, etc. This category is not meant to cover additional space needs, only the layout of existing spaces.*

****

Good = *System(s) less than 10 years old and/or no documented major problems. Only routine maintenance required to keep building completely functional.*

Fair = *System(s) more than 10 years old and/or some components need replacement. Documented problems could be corrected with a renovation project and useful life of building extended for at least another 10 years.*

Poor = *System(s) of any age which are approaching or are beyond the end of their useful life. Complete replacement necessary to maintain a proper environment for patients and staff.*

	Category / System	Good	Fair	Poor	Don't Know
F3.1	Structural				
F3.2	Mechanical				
F3.3	Electrical				
F3.4	Energy Management				
F3.5	Handicap Access				
F3.6	Site / Environmental				
F3.7	Fire / Life Safety				
F3.8	Floor Plan				

Comments:

Structural:_____

Mechanical: _____

Electrical:_____

Energy Management:_____

Handicap Access:_____

Site / Environmental:_____

Fire / Life Safety:_____

Floor Plan:_____

F3.9 Check the box below that best describes the overall condition of the facility.

☐ Good

☐ Fair

☐ Poor

F3.10 Check the box below that best describes what your organization and the community as a whole think should be done with the facility.

- ☐ Correct deficiencies, renovate and/or add space and remain in service
- ☐ Replace with new facility
- ☐ Don't know or no consensus

F3.11 Is there a system for documenting deficiencies in the facility?

- ☐ NO
- ☐ YES

If yes, please describe _____

F3.12 Is there a cost estimate to correct some or all of the physical deficiencies summarized above?

- ☐ NO *If no, go to subsection F4.0.*
- ☐ YES - All
- ☐ YES - Some

If yes, estimate = $ _____

Date of estimate: _____

Check the boxes that apply to the estimate.

- ☐ Prepared by an Engineer or Contractor
- ☐ Includes design and project management fees
- ☐ Includes a construction contingency

F3.13 Has your organization and/or the community received a commitment from a funding source to correct the above deficiencies?

- ☐ NO
- ☐ YES
- ☐ PARTIAL

If yes or partial, please list

1. Source: _____ *Amount: $* _____

2. Source: _____ *Amount: $* _____

3. Source: _____ *Amount: $* _____

Comments:

F4.0 Space Related Deficiencies

F4.1 Do you need a facility where none exists now, or more space in an existing facility? Check all that apply.

☐ NO *If no, go to subsection F5.0.*

☐ YES – and a planning document has been prepared for either an addition, replacement or new first time facility

☐ Addition = _____ *GSF*

☐ New facility = _____ *GSF*

☐ YES – but don't know how much

F4.2 Is there a business plan that details how additional services and space will be financially supported?

☐ NO

☐ YES

If yes, please check the box below that best describes what the total ownership, repair, utility and maintenance budget would be for the new facility (do not include program costs).

☐ $1 - $50,000

☐ $50,001 - $100,000

☐ $100,001 - $200,000

☐ $200,001 - $300,000

☐ $300,001 - $400,000

☐ $400,001 - $500,000

☐ Greater than $500,000

☐ Don't Know

F4.3 Is there a cost estimate to construct the new space?

☐ NO *If no, go to question F4.4.*

☐ YES

If yes, estimate = $ _____

Date of estimate: _____

Check the boxes that apply to the estimate.

☐ Prepared by an Engineer or Contractor

☐ Includes design and project management fees

☐ Includes a construction contingency

☐ Includes cost of new medical equipment

F4.4 Has your organization and/or the community received a commitment from a funding source to correct the space related deficiencies?

☐ NO

☐ YES

☐ Partial

If yes or partial, please list

1. Source: _____ *Amount: $* _____

2. Source: _____ *Amount: $* _____

3. Source: _____ *Amount: $* _____

F4.5 Has the community made a commitment to provide in-kind contributions for the project?

☐ NO

☐ YES

F4.6 Are matching funds available for the project? Check all that apply.

☐ Regional Native Health Corporation

☐ State

☐ Federal Government

☐ Other *(list)* _____

F4.7 Is a design complete for the project?

☐ NO

☐ YES

☐ Under development

F4.8 Has a site been identified for the project?

☐ NO *If no, go to question F4.11.*

☐ YES

F4.9 Have all site control issues been resolved?

☐ NO

☐ YES

F4.10 Is the site close to existing infrastructure and primary community services, including water/sewer lines, power, local roads, airstrip, EMS office, school(s), etc. Check the box that best describes the site in this regard.

☐ Good – no major off site work required and in a convenient location to other primary community services

☐ Fair – some off site work required to connect utilities and/or location is inconvenient with respect to one or two other primary community services

☐ Poor – significant off site work required to connect to utilities and/or location is remote from most other primary community services

F4.11 Are there other funding sources or potential resource enhancement opportunities that would be more accessible if a new facility was constructed in the community?

☐ NO

☐ YES

If yes, please list

1. _____

2. _____

3. _____

☐ Don't Know

F4.12 Is there a new clinic or major clinic renovation project for the community that is approved and awaiting funding by a government entity or other outside source?

☐ NO

☐ YES

If yes, check the box that most closely describes the status of your project.

☐ Funding anticipated within 2 years

☐ Funding anticipated between 2 and 5 years

☐ Funding year uncertain

Comments:

F5.0 Medical Equipment Deficiencies

F5.1 Is the existing facility in need of new or replacement capitalized medical equipment? *Note: capitalized medical equipment is fixed or movable medical equipment greater than $500 in value.*

☐ NO

☐ YES

If yes, is there a cost estimate for the needed equipment?

☐ NO

☐ YES *Estimate = $* _____

F5.2 Does the facility have access to funds from any of the following sources for capitalized medical equipment?

☐ IHS

☐ State

☐ Regional Native Health Corporation Medical Equipment Fund

☐ Medical Equipment Fund at your parent organization

☐ Other *(list)* _____

If you checked any of the above five boxes, what is your estimate of the remaining funds necessary to meet your current medical equipment needs?

Estimate = $ _____

Comments:

F6.0 Utility and Maintenance Data

F6.1 Please provide the following energy data for calendar year 1998.

Total electrical usage at facility = _____ Kilowatt-hours

Total fuel oil usage at facility = _____ Gallons

Total natural gas usage at facility = _____ Cubic Feet

Total other energy sources (e.g. waste heat, coal etc.) = _____ Million BTU's

Other *(list)* _____

F6.2 On average, what are the annual costs for utilities and routine maintenance activities at the facility? Include costs for all utilities, building service contracts, maintenance benchstock and supplies, maintenance training, and small (less than $10,000) in-house repair / remodel projects. Do not include wages for maintenance staff.

$ _____ *per year*

F6.3 What funds are used to pay for ownership, repair, utility and maintenance costs at the facility? Check all the boxes that apply.

- ☐ IHS Village Built Clinic lease funds
- ☐ IHS / ANTHC Maintenance and Improvement funds
- ☐ Regional Native Health Corporation Funds
- ☐ Clinic Operating Funds
- ☐ City Funds
- ☐ State Funds
- ☐ Private Funds (e.g. contributions by building owner)
- ☐ Other *(list)* _____

F6.4 Is there a regional or other non-local support system for facilities management issues that your facility / staff can access?

- ☐ NO
- ☐ YES

If yes, indicate the lead organization for this support _____

F6.5 Does the owner of the facility have a building replacement and depreciation fund?

- ☐ NO
- ☐ YES
- ☐ Don't Know

Comments:

Certification: *The above information is true and accurate to the best of my knowledge.*

_____ _____
Signature *Date*

_____ _____
Printed Name *Position*

The following additional individuals participated in the completion of this section of the questionnaire.

_____ _____
Printed Name & Position *Printed Name & Position*

_____ _____
Printed Name & Position *Printed Name & Position*

The facilities section is now complete.

PROGRAM

Community _____ **Unique ID #** _____

Organization _____

P1.0 Services

The services listed in questions P1.1 – P1.41 and P4.1 – P4.7 may be considered components of comprehensive primary care. These services may be provided by a variety of health care providers, including Community Health Aides / Practitioners, Nurse Practitioners, Physician Assistants, Physicians, etc. Please indicate whether your program provides these services and functions. A "YES" answer implies that these services are provided on a regular basis by full or part time local staff. If you answered "NO" or "Itinerant Basis Only" please indicate why by checking one or more boxes to the right, and then indicate if any of the services should be provided on a regular basis to meet local program and/or community goals.

Key:
Avail. = Available
Comm. = Community
Inadeq. = Inadequate
Itin. = Itinerant / Contract

		Currently Provided?			*If Not, Why? (check all that apply)*							*Should Be Provided?*	
		Yes	Itin. Basis Only	No	Not Needed In This Size Comm.	Not Wanted By Comm.	Inadeq. Funding	Inadeq. Space	Inadeq. Equip.	Inadeq. Staff Avail.	Other	Yes	No
Basic Primary Care Services Related To													
P1.1	Family Health												
P1.2	Emergency Medical Treatment												
P1.3	Substance Abuse Diagnosis												
P1.4	Substance Abuse Treatment												
P1.5	Mental Health Diagnosis												
P1.6	Mental Health Treatment												

Comments:

Key:
Avail. = Available
Comm. = Community
Inadeq. = Inadequate
Itin. = Itinerant / Contract

		Currently Provided?			*If Not, Why? (check all that apply)*							*Should Be Provided?*	
		Yes	Itin. Basis Only	No	Not Needed In This Size Comm.	Not Wanted By Comm.	Inadeq. Funding	Inadeq. Space	Inadeq. Equip.	Inadeq. Staff Avail.	Other	Yes	No
Preventive Health Services													
P1.7	Prenatal and Perinatal Services												
P1.8	Breast and Cervical Cancer Screening												
P1.9	Well-Child Services												
P1.10	Immunizations												
P1.11	Supplemental Nutrition Program (WIC)												
P1.12	Family Planning Services												
P1.13	Preventive Dental Services												
P1.14	Dental Treatment Services												
P1.15	Patient Education												
P1.16	Other (list)												

Comments:

Key:
Avail. = Available
Comm. = Community
Inadeq. = Inadequate
Itin. = Itinerant / Contract
CLIA = Clinical Laboratory Improvement Act

		Currently Provided?			*If Not, Why? (check all that apply)*							*Should Be Provided?*	
		Yes	Itin. Basis Only	No	Not Needed In This Size Comm.	Not Wanted By Comm.	Inadeq. Funding	Inadeq. Space	Inadeq. Equip.	Inadeq. Staff Avail.	Other	Yes	No
Laboratory, Radiological and Pharmacy Services													
P1.17	CLIA Waived Tests												
P1.18	Specimen Collection for Shipment to Referral Lab												
P1.19	Provider Performed Microscopy												
P1.20	Moderate Complexity Lab												
P1.21	Ultrasound												
P1.22	X-Ray												
P1.23	Mammography												
P1.24	Pharmacy Services												

Comments:

Key:
Avail. = Available
Comm. = Community
Inadeq. = Inadequate
Itin. = Itinerant / Contract

		Currently Provided?			*If Not, Why? (check all that apply)*							*Should Be Provided?*	
		Yes	Itin. Basis Only	No	Not Needed In This Size Comm.	Not Wanted By Comm.	Inadeq. Funding	Inadeq. Space	Inadeq. Equip.	Inadeq. Staff Avail.	Other	Yes	No
Patient Case Management Services													
P1.25	Referral of Patients to Providers												
P1.26	Counseling and Follow-Up Services to Assist Patients to Become Eligible for Health Care Coverage												

Comments:

Key:
Avail. = Available
Comm. = Community
Inadeq. = Inadequate
Itin. = Itinerant / Contract

		Currently Provided?			*If Not, Why? (check all that apply)*							*Should Be Provided?*	
		Yes	Itin. Basis Only	No	Not Needed In This Size Comm.	Not Wanted By Comm.	Inadeq. Funding	Inadeq. Space	Inadeq. Equip.	Inadeq. Staff Avail.	Other	Yes	No
Services That Help Individuals to Use Clinic													
P1.27	Outreach												
P1.28	Home to Clinic Transportation												
P1.29	Language Interpretation												
P1.30	Sliding Fee Scale / Reduced Rates												
P1.31	Alternate / Extended Hours												

Comments:

Key:
Avail. = Available
Comm. = Community
Inadeq. = Inadequate
Itin. = Itinerant / Contract

		Currently Provided?			*If Not, Why? (check all that apply)*							*Should Be Provided?*	
		Yes	Itin. Basis Only	No	Not Needed In This Size Comm.	Not Wanted By Comm.	Inadeq. Funding	Inadeq. Space	Inadeq. Equip.	Inadeq. Staff Avail.	Other	Yes	No
Community Health Services													
P1.32	Education on Availability and Appropriate Use of Services												
P1.33	Off Site Services (e.g., school, senior center)												
P1.34	Home Health Visits												
P1.35	Personal Care Services												
P1.36	Community Health Education & Health Promotion												

Comments:

Key:
Avail. = Available
Comm. = Community
Inadeq. = Inadequate
Itin. = Itinerant / Contract

		Currently Provided?			*If Not, Why? (check all that apply)*							*Should Be Provided?*	
		Yes	Itin. Basis Only	No	Not Needed In This Size Comm.	Not Wanted By Comm.	Inadeq. Funding	Inadeq. Space	Inadeq. Equip.	Inadeq. Staff Avail.	Other	Yes	No
Emergency Medical Services													
P1.37	First Responder Services												
P1.38	Ambulance Services												
P1.39	Ability to Provide Advanced Cardiac Life Support in Clinic												
P1.40	Dedicated Area for Dealing with Emergency Patients												
P1.41	Radio Communications Between Clinic & Emergency Medical Personnel												

Comments:

P2.0 Transportation

P2.1 Do you arrange for transport to other communities for care?

- ☐ NO
- ☐ YES

P2.2 What is the primary mode of travel to the next level of care?

- ☐ Motor Vehicle
- ☐ Airplane
- ☐ Boat
- ☐ Other *(list)* _____

P2.3 For routine referrals, what is the average travel time to the next level of care (door-to-door)?

- ☐ Less than 1 hour
- ☐ 1 – 2 hours
- ☐ 2 – 6 hours
- ☐ more than 6 hours

P2.4 In emergencies, what is the average travel time to the next level of care (door-to-door)?

- ☐ Less than 1 hour
- ☐ 1 – 2 hours
- ☐ 2 – 6 hours
- ☐ more than 6 hours

P2.5 What were your total travel costs for patient and accompanying staff to the next level of care in calendar year 1998?

$ _____

- ☐ Don't Know

Comments:

P3.0 Administration

P3.1 What term best defines the organization that provides administration of your program?

- ☐ Private, for profit
- ☐ Private, not for profit
- ☐ City/Borough
- ☐ PL 93-638 Contract / Compact
- ☐ Other *(explain)* _____
- ☐ N/A *If n/a go to question P3.3*

P3.2 Does the facility have a governing board / body?

- ☐ NO
- ☐ YES

P3.3 Check the box in each column that most accurately describes the budget situation for your health services delivery program. *Note: this question relates only to "program" budget, i.e., excludes facility ownership, repair, utility and maintenance costs, which are addressed separately in the Facilities section of the questionnaire.*

	Current Operating Budget	***Current Deficits***	***Total Projected Operating Budget if all Needed Services Were Provided***
Annual Amounts			
$0			
$1 - $50,000			
$50,001 - $100,000			
$100,001 - $150,000			
$150,001 - $200,000			
$200,001 - $250,000			
$250,001 - $300,000			
$300,001 - $350,000			
$350,001 - $400,000			
$400,001 - $450,000			
$450,001 - $500,000			
Greater Than $500,000			

P3.4 Check all the funding sources that apply, or would apply, to your health services program. Checking a box is the same as answering yes. Blank boxes will be interpreted as either a NO or Don't Know response. *Note: this question relates only to "program" budget, i.e., excludes facility ownership, repair, utility and maintenance costs, which are addressed separately in the Facilities section of the questionnaire.*

		Using Now	***Would Use if all Needed Services Were Provided***
Funding Sources			
P3.4.1	Medicaid		
P3.4.2	Denali KidCare		
P3.4.3	Medicare		
P3.4.4	Other Health Insurance		
P3.4.5	Federal Grants		
P3.4.6	State Grants		
P3.4.7	Other Grants		
P3.4.8	Private Pay		
P3.4.9	P.L. 93-638		
P3.4.10	Community Subsidy		
P3.4.11	Other *(list)*		

Comments:

P4.0 Support Services

The following is a list of support services. Please check all the boxes that apply.

		Done On-Site by Local Staff?	***Done On-Site by Itinerant/Contract Staff?***	***Done Off Site?***	***Not Done***
Support Services					
P4.1	Medical Records				
P4.2	Accounting / Budget				
P4.3	Billing / Collections				
P4.4	Computer Information Support				
P4.5	Facilities Management				
P4.6	Janitorial Services				
P4.7	Staff Development / In-Service				

Comments:

P5.0 Staffing

The following is a list of staff. For each type of staff, please indicate the number of funded positions you have, the number of positions filled and the number needed. Also indicate if you use Itinerant or Contract staff. Please report positions in terms of "Full-time equivalents (FTE's)".

Key:	
Full-time employee	1.0 FTE
4 days/week	.8
3 days/week	.6
Half-time	.5
2 days/week	.4
1 day/week	.2
0 days/week	0

		Number of Funded Positions	***Number of Filled Positions***	***Additional Number of Positions Needed***	***Itinerants or Contract Staff***	
					Current	***Additional Needed***
Staffing Services						
P5.1	Director / Clinical Manager					
P5.2	Business Manager					
P5.3	Billing / Collections Staff					
P5.4	Computer Information Staff					
P5.5	Clerical / Reception/Travel					
P5.6	Medical Records Staff					
P5.7	Maintenance / Janitorial Staff					
P5.8	Community Health Aide / Practitioner					
P5.9	Community Health Representative					
P5.10	Rural Human Services Worker					
P5.11	WIC Staff					
P5.12	Emergency Medical Technician					
P5.13	Nurse					
P5.14	State/Contract Public Health Nurse					
P5.15	Nurse Practitioner					
P5.16	Physician Assistant					
P5.17	Physician					
P5.18	Dental Hygienist					
P5.19	Dentist					
P5.20	Other (list)					

Comments:

P6.0 Clinical Caseload (Workload) Data

P6.1 Is caseload data available for your program?

☐ NO *If no, go to question P6.5.*

☐ YES

☐ N/A *If n/a, answer question P6.5 and then skip to section 8.0.*

P6.2 How many total patient encounters / visits were reported in your program in calendar year 1998?

_____ *(write in number)*

☐ Don't Know

P6.3 How many total dental encounters / visits were reported in your program in calendar year 1998?

_____ *(write in number)*

☐ Don't Know

P6.4 How many emergency medical patients were seen in your facility in calendar year 1998?

_____ *(write in number)*

☐ Don't Know

P6.5 Is there a significant seasonal or itinerant population in your community that requires health services?

☐ NO *If no, go to subsection P7.0.*

☐ YES

If yes, is the population high risk? Check all that apply below.

☐ Fishing

☐ Logging

☐ Tourism

☐ Other *(list)* _____

If yes, do many of these individuals experience a language barrier at your facility?

☐ NO

☐ YES

Comments:

P7.0 Extended Patient Stays *(greater than 4 hours)*

P7.1 Does your primary care facility ever treat patients for extended stays including overnight?

- ☐ NO *If no, go to subsection P8.0.*
- ☐ YES

P7.2 If you answered "YES" to question P7.1, how often were patients treated for extended stays in calendar year 1998?

- ☐ 1-5 times
- ☐ 6-10 times
- ☐ 11-20 times
- ☐ More than 20 times

P7.3 Why did these patients require extended stays in your facility? Check all that apply.

- ☐ Lack of adequate transportation
- ☐ Could not transport patient(s) out of community due to weather
- ☐ Condition of patients(s) required extended observation or treatment, but not out of community
- ☐ Other circumstances *(please explain below)*

_____

P7.4 Is your facility equipped to accommodate patients overnight?

- ☐ NO
- ☐ YES

Comments:

P8.0 Living Quarters

P8.1 Do you have living quarters available for Itinerant / Contract staff? Select one response that best describes the situation.

- ☐ NO
- ☐ YES – in clinic
- ☐ YES – in community

P8.2 Do you have living quarters available for permanent staff? Select one response that best describes the situation.

- ☐ NO
- ☐ YES – in clinic
- ☐ YES – in community

P8.3 If you answered "NO" to question P8.1 or P8.2, do you believe that dedicated living quarters for clinic staff are needed? Check all responses that apply.

- ☐ NO
- ☐ YES – in the clinic
- ☐ YES – in the community but not in the clinic
- ☐ YES – this affects our ability to provide certain health care services

Comments:

P9.0 Telehealth

P9.1 Does your main referral facility have an advanced medical communication system in place that takes advantage of new telemedicine technology?

- ☐ NO
- ☐ YES
- ☐ Under Development
- ☐ Don't Know

P9.2 If you currently have, or plan to have telemedicine equipment available in your facility, do you have adequate space for it?

- ☐ NO
- ☐ YES
- ☐ Don't Know

Comments:

Certification: *The above information is true and accurate to the best of my knowledge.*

Signature	*Date*
Printed Name	*Position*

The following additional individuals participated in the completion of this section of the questionnaire.

Printed Name & Position	*Printed Name & Position*
Printed Name & Position	*Printed Name & Position*

ADDITIONAL COMMENTS

Community _____ **Unique ID #** _____

Organization _____

Name of Facility _____

Question Number ☐ _____

Question Number ☐ _____

Question Number ☐ _____

Question Number ☐ _____

Question Number ☐ _____

ADDITIONAL COMMENTS

Community _____ **Unique ID #** _____

Organization _____

Name of Facility _____

Question Number ☐ _____

Question Number ☐ _____

Question Number ☐ _____

Question Number ☐ _____

Question Number ☐ _____

DID YOU REMEMBER TO

For Hard Copy Submissions

☑ Enter the community, facility and program identification information at the beginning of the General, Facilities, and Program Sections of the questionnaire.

☑ Sign the certification at the end of all applicable sections of the questionnaire.

☑ Return the General Section of the questionnaire.

☑ Return the appropriate number of Facilities and Program Sections of the questionnaire.

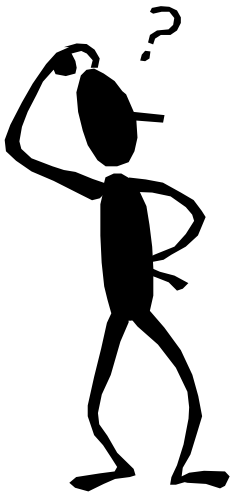
☑ Keep copies of all sections for your records.

For Electronic Submissions via the Project Web Site

☑ Complete the appropriate number of Facilities and Program Sections of the questionnaire.

☑ Print a copy of all sections for your records.

Complete Questionnaires and Submit Data by April 25, 2000



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Questionnaire

NANA/DOWL ENGINEERS
A Division of DOWL LLC

4040 "B" Street
Anchorage, Alaska 99503
Phone: 907.562.2000; Fax: 907.563.3953
Web Site: www.dowl.com

Web Site Design and Database

GEONORTH
INTERNET • GIS • DATABASE

3330 Arctic Boulevard, Suite 101
Anchorage, Alaska 99503
Phone: 907.562.1500; Fax: 907.562.1502
Web Site: www.geonorth.com

Printing

KEN WRAY'S PRINTING

323 East Fireweed Lane
Anchorage, Alaska 99503
Phone: 907.276.4535; Fax: 907.278.5775